National Rural Health Association

May 28, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1802-P; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) fiscal year (FY) 2025 Skilled Nursing Facilities Prospective Payment System proposed rule. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

III. Proposed SNF PPS Rate Setting Methodology and FY 2024 Update.

CMS proposes to update skilled nursing facility (SNF) payments by 4.1%, or $1.3 billion total, compared to FY 2024 payments. This translates to a 4.9%, on average, increase in payments for rural SNF providers which includes an upward wage index adjustment. **NRHA thanks CMS for the significant payment increase for FY 2025** and encourages the agency to continue to maximize support for rural SNFs. NRHA is also pleased to see a 1.7% forecast error adjustment applied to the FY 2025 payment rate to correct for the underestimated market basket increase in FY 2024.

Rural SNFs have long faced inadequate reimbursement that does not cover the cost of providing care to its rural residents, which may be one factor that contributed to 472 rural nursing home closures from 2008 – 2018.[1] The long-term care sector was hit hard by the pandemic and rural SNFs are still grappling with workforce challenges, increased costs, and continuing facility closures. NRHA again thanks CMS for this increase and hopes to see sufficient Medicare reimbursement to SNFs continue in order to help support their viability and maintain access to post-acute care in rural areas.

[1] Hari Sharma, et al., *Trends in Nursing Home Closures in Nonmetropolitan and Metropolitan Counties in the United States, 2008-2018*, RUPRI CENTER FOR HEALTH POLICY ANALYSIS, Feb. 2021, at 3, https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf.

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VIII. Nursing Home Enforcement.

NRHA supports the Administration's commitment to ensuring that nursing home residents receive safe, high-quality care. However, **NRHA cautions CMS against imposing heavier civil monetary penalties (CMPs) against rural facilities that cannot shoulder extra costs.**

Currently, CMS or state agencies decide whether to impose per day (PD) or per instance (PI) CMPs during a survey. Historically, PD and PI CMPs have been imposed in different circumstances. PI CMPs are generally used for a one-time noncompliance unrelated to resident safety that was corrected prior to a survey. On the other hand, PD CMPs are often imposed for chronic noncompliance causing actual harm to residents.

CMS proposes to expand its nursing home enforcement authority by changing the selection of remedies to allow PD CMPs of up to $10,000 and PI CMPs of up to $10,000 for the same instance of noncompliance. CMS is adding that they may impose a combination of PI and PD CMPs for each instance within the same survey, but the aggregate CMP cannot exceed $10,000 for each day of noncompliance. Additionally, CMS proposes that they may impose CMPs for the number of days that a facility is not in substantial compliance with participation requirements or for each instance, or both, whether or not the deficiencies constitute immediate jeopardy. This includes imposing CMPs for days of past noncompliance for the previous three standard surveys.

NRHA has several concerns with the proposals above. The potential amount of CMPs that CMS may levy against rural facilities could be devastating. Total CMPs per day are limited, but depending on the number of days of noncompliance and whether both PI and PD CMPs are imposed, the total penalty amount could be extremely high. This expansion of authority for CMS and state agencies equates to unfair duplicative payments put on the back of struggling rural facilities. For example, a small, rural NRHA member facility saw over $1.5 million in CMPs imposed by the state under the current CMP policy. This amount was negotiated down to $60,000, which is still a substantial sum with the potential to close the rural facility. CMS' proposal to grow its enforcement authority and impose concurrent CMPs would likely result in much higher total CMPs. **NRHA urges CMS to rethink its proposals on allowing PI and PD CMPs to be imposed for the same instance of noncompliance and evaluate the impact that this would have on rural facilities. Heavy and concurrent CMPs should be reserved for instances that threaten actual harm to nursing home residents.**

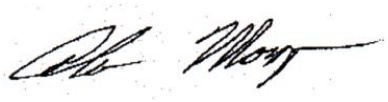
CMS notes that in 2022, the number of facilities that 41% of all facilities received CMPs. The average total amount of the CMPs imposed for each facility in 2022 was $17,775. Again, this figure is likely to grow as CMS proposes to grow its authority to levy CMPs. It is troubling that almost half of facilities received CMPs in 2022, but even more troubling is the prospect of these facilities seeing much higher penalties imposed. **Rural facilities in particular cannot take on additional costs and already struggle under the current CMP system.**

NRHA is also extremely concerned about the lookback period for imposing CMPs. As mentioned above, CMS would be able to impose CMPs for days of past noncompliance for the number of days of past noncompliance since the last three standard surveys. This is an unreasonable lookback period for imposing penalties for noncompliance. A three-survey period could translate to a 4-to-5-year

lookback due to the 15-month survey cycle. In some cases, surveys are not performed every 15 months because state survey agencies are understaffed. This would extend the lookback period even further. **NRHA encourages CMS to remove this proposal or limit sanctions to the last survey period.** When past grievances have been addressed an extended lookback time for imposing CMPs would be financially ruinous for rural nursing homes that are operating on thin margins.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care. If you would like additional information, please contact Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
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